

Kentucky Board of Nursing

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VERIFICATION OF EMPLOYMENT

ATTACHMENT 1

6/2006

Complete this form only if you are reinstating your RN/LPN Kentucky license.

To the Applicant Complete this section of the Verification of Employment form. In the spaces below, list an employer who will verify that you practiced as a nurse 500 hours during the past five years. THE EMPLOYER MUST MAIL OR FAX THIS FORM TO THE KENTUCKY BOARD OF NURSING. Applicant's Last Name: **Applicant's First Name:** Year of Graduation From Basic PON: Social Security #: () LPN RN Employed As: **Employing Facility:** Facility's Address: City: State: Zip: Facility's Phone #: Employed From (Month/Year): Employed To (Month/Year): To the Employer/Previous Employer -Complete this section of the Verification of Employment form, and MAIL OR FAX THIS FORM DIRECTLY TO THE KENTUCKY BOARD OF NURSING. Has the above named individual been engaged in active nursing practice for at least 500 hours during the past five years at this facility? If no, list the number of hours of practice: **Facility Name Employer's Name (Please Print)** Title & Phone # **Employer's Signature** Date Office Use Only -Person Contacted at Above Facility: Employment Verified? If no, explanation rec'd: Title of Person Contacted: Yes No Date & Time Contacted: ____